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MEDICAL RECORDS RELEASE FORM

All sections of this authorization form MUST be completed to be valid in accordance with 42 CFR Parts 160 and 164

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

E-mail Address: _____ Phone: _____

I request my protected health information (PHI) from:

☐ Rockhill Orthopaedic Specialists ☐ Other: _____

I request my protected health information (PHI) to be released to:

Name: _____ E-mail Address: _____

Address: _____ Phone: _____

City/State: _____ Zip Code: _____ Fax# (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

- | | | |
|--|--|---|
| <input type="checkbox"/> Complete Medical Record (all pages) | <input type="checkbox"/> Laboratory Report(s) | <input type="checkbox"/> Radiology films/images |
| <input type="checkbox"/> Progress/Office Note(s) | <input type="checkbox"/> Work Status Report(s) | <input type="checkbox"/> Radiology Report(s) |
| <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> Medication Listing | <input type="checkbox"/> Detailed Billing |
| <input type="checkbox"/> Other: _____ | | |

Purpose for requesting information:

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Legal | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Continuation of Care |

How information is to be received:

- | | |
|--|--|
| <input type="checkbox"/> US Mail - paper format | <input type="checkbox"/> Fax (to healthcare provider only) |
| <input type="checkbox"/> CD - secure electronic format | <input type="checkbox"/> Pick up in office - paper format |

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____
If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative Signature: _____ Date: _____ Time: _____

Printed name of authorized representative: _____ Relationship to patient: _____

Witness Signature: _____ Date: _____ Time: _____

If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.